

STATE OF IDAHO  
SUMMARY OF PAYMENTS  
NON-FATAL CASES

IC No. \_\_\_\_\_ County: \_\_\_\_\_ SSN: \_\_\_\_\_

Surety Claim No.: \_\_\_\_\_ Policy Yr. \_\_\_\_\_

Injured Person: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Business: \_\_\_\_\_  
 \_\_\_\_\_ Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Character of Injury: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Weekly Wage: \_\_\_\_\_

Date RTW: \_\_\_\_\_ Comp. Rate: \_\_\_\_\_

Last check date: \_\_\_\_\_

INDEMNITY							MEDICALS	
Dis- abil- -ity Type	\$ Amounts		wks	days	Beginning Date of Disability	Last Date of Disability	Service Type	\$ Amount
	\$ Total	\$/Wk rate						
							DOCTOR	
							HOSP	
							PHYS TH	
							MILEAGE	
							MISC	

Note: A new period of disability must be itemized each time Comp Rate changes; or Type of Disability changes; or there is a break in continuity.

Notes: \_\_\_\_\_ Industrial Commission Approval: \_\_\_\_\_

Surety: \_\_\_\_\_

Adjuster: \_\_\_\_\_

by: \_\_\_\_\_ Date: \_\_\_\_\_

IC FORM 6(7-1-97)